MEETING MINUTES

Project Name: IPRS	**Doc. Version No:** 1.0	**Status:** Final

Meeting Name:	IPRS Core Team Meeting
Facilitator:	Eric Johnson, DMH
Scribe:	Evelyn Woodard
Date:	09/03/2008
Time:	10:45 – 12:00 PM
Location:	Wycliff Room 430

IPRS Core Team Attendees:

	Gary Imes
x	Thelma Hayter
x	Eric Johnson
x	Travis Nobles
	Cheryl McQueen
x	Sharlene Bryant
	Jamie Herubin
	Mike Frost
x	Myran Harris
x	Jay Dixon, Budget Office

Others:

	Cathy Bennett
x	Sandy Flores
x	Paul Carr
x	Evelyn Woodard
	Chris Ferrell
x	Rick Kretschmer
	Theresa Diana
	Susie Pezzoni
x	Dana Jackson

Attendees:

x	Alamance-Caswell
x	Albemarle
	Centerpoint
	Crossroads
x	Cumberland
x	Durham
x	Eastpointe
x	ECBH
x	Five – County MHA
x	Guilford
x	Johnston
x	Mecklenburg
x	Mental Health Partners
x	Onslow-Carteret
x	OPC
x	Pathways
x	Piedmont
x	Sandhills
x	SE Center
x	SE Regional
x	Smoky Mountain
x	The Beacon Center
x	Wake
x	Western Highlands

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Attendees:	
Item No. Topics	1. Roll call 2. Please mute phones or refrain from excess activity to help with communications. Please state your name and which "area program" you are from when you speak. **Also, please do not place IPRS Core Team call on hold because of potential distraction to call discussion.** 3. Upcoming Checkwrites (cut-off dates) – **September 4, 11, 18** 4. Agenda items – **Divisional Updates** • **Audit Changes to Adult and Child Enhanced Services** • **Alternative Services** • **Reporting of County Funds** • **IPRS Simplification** 5. IPRS Questions or Concerns 6. MMIS Updates – Dana Jackson 7. DMH and/or EDS concluding remarks. a. For **North Carolina Medicaid** claim questions / inquiries, please call EDS Provider Services at 1-800-688-6696 or 1-919-851-8888 and enter the appropriate extension listed below or 0 for the operator. i. Physician phone analyst (i.e. Independent mental Health Providers) – 1 ii. Hospital phone analyst (i.e. Enhanced Service Providers / LMEs) – 2 b. Roll Call Updates

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IPRS Question and Answer email address – iprs.qanda@ncmail.net

ADMINISTRATION NOTES (10:30 a.m. AREA PROGRAMS CONFERENCE CALL)	
Item No.	**Topics**
1.	Roll Call
2.	Please mute phones or refrain from excess activity to help with communications. Please state your name and which "area program" you are from when you speak. **Also, please do not place IPRS Core Team call on hold because of potential distraction to call discussion.**
3.	**Upcoming Checkwrites** (cut-off dates) September 4, 11, 18
4.	**Agenda items** • Upcoming Checkwrite (cutoff dates) – September 4, 11, 18 Eric (DMH) – We did not have a checkwrite last week. We have a checkwrite this week and the cutoff date is September 4. Are there any questions or concerns related to the checkwrite? Q. Amy (Five County) – The file that we sent on 8/21/08, there were a lot of errors reported. IPRS stated they intend to pend the file until the following week. In the process, we've made some corrections to one of the IPRS provider screens. The question is since they have pended the file and now we made corrections to the provider screen, will the corrections be in effect for this checkwrite for this pended file or do we need to resubmit that file? Q. Travis (DMH) – Amy, is this the one you have talked with Tim Gwyn about? A. Amy (Five County) – Yes, it is regarding that issue. A. Travis (DMH) – The changes are immediate in the PQ screen and the file is rather large. There is a lot of detail in which I will send to you. Tim Gwyn answered all your questions. The file was pended and if you've made the changes that information is there now. So when you resubmit the file, those changes will take affect. • Divisional Updates Eric (DMH) – We have a few Divisional updates and changes we would like to go over with you at this time as well as a review of several IPRS User Alerts, one in which you will be receiving by the end of this week. Thelma (DMH) – Good morning everyone. I would like to give you an update on some of the things that have been discussed in our meetings. 1. Audit changes to Adult and Child Enhanced Services – We have some changes as you know with the Medicaid and IPRS enhanced services. These changes will affect you. We have some audits that will be implemented for the child enhanced services that will tell you whether or not you can bill those services on the same day. What we added was the ability for you to go into IPRS and enter in a prior approval to override that audit. There are ten to twelve that will be going into effect this Friday. So please watch for the IPRS User Alert from EDS that will explain these audit changes, which services can and cannot be billed on the same day, how you can override these audits with the prior approval, and the new EOB's if you attempt to submit these services without a prior approval. Also, we had some changes to the adult enhanced services audits that will be going into production Friday. Community Support has changed its limit to 32 units per week. An IPRS User

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	Alert will be forwarded to you regarding the enhanced services this Friday as well, so please watch for this user alert. Also, the Division will work on providing you a cheat-sheet summation, similar to the one forwarded to you by Cheryl McQueen on the EOBs. I am uncertain this will sent to you by Friday, but it will be sent to you shortly. So please watch for the IPRS User Alerts and the cheat-sheet information, and if we need to have another conference call other than the Core Team conference call to go over this information, we can schedule this for you. Once you receive this information and there are questions or concerns related to the audit changes, please send them to IPRS Q&A and if you need to schedule an extra meeting to go over the information, please send your request to IPRS Q&A. Are there any questions or concerns related to the audit changes for Adult and Child enhanced services? Q. Tom (WH) – The child audits you are introducing includes the ability to override the 8 hours per week limitation for Community Support? A. Thelma (DMH) – No, unfortunately community support cannot be overridden because of Legislation law. A. Tom (WH) – They offered under EPSDT that DMA make an exception to the 8 hour day limitation, but IPRS state funding does not have a similar program. A. Thelma (DMH) – Yes, you are right. Q. Terry (Eastpointe) – In regards to the new EOB' I received an EOB7005, which states maximum number of units allowed per week has been exceeded for Community Support. This client has only received 6 hours of service for that week, but was denied for the next two service dates. Q. Thelma (DMH) – Could you please forward your ICN to IPRS Q&A, so that we may research this further for you? A. Terry (Eastpointe) – Sure. 2. Alternative Services – The Finance Officers attended a meeting two weeks ago by which Bonnie Morel addressed Alternative Services with the group. The process is the LME's that have the alternative services they want to use for their LME fill out a form and that form is in a bulletin on the DMH Website. Some of you have filled out this form and have turned them in to the Division. These completed forms have gone into review by best practices and they were presented to the Divisional Workgroup where multiple disciplines could review them and discuss them. They have completed this process and the next step is to need be presented to our ELT team or management team. Also, they need to have their rates reviewed. Wanda Mitchell was not in the office this week, and I am not sure if the budget office has had the opportunity to review the forms. We will need to review the rates and then it will go to ELT. Once all of this has been approved, then we can get them entered into IPRS. The way that we are projecting to do that is you have the rate entered in for your LME and only those LMEs approved by the Division for this service will have their rates entered and this is how the LME will get paid. If another LME submits that procedure code and it will deny for no rate on file at this point because the service has not been approved for the all of the LMEs. Now, I know that we have gone back and forth with the there is no alternative service and can everyone use it or is it exclusive for the LMEs submitting it. The word from Leza Wainwright is that at this point this is a pilot project and we are having only the LMEs that submitted the requested the form have access to the procedure code to be able to bill for and report on. We may develop another solution later on that gives a different denial code in which the description is a little more elaborate than no rate on file. This will work once ELT approves the service and the rate and everything around it. Are there any questions or concerns related to the Alternative

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services?
Q: Dennis (PBH) – What is the time frame?
A: Thelma (DMH) – I know that you are anxious to get this entered in by the end of October and because you've got 23 services there. So, we cannot promise you that these will be in by the end of October, but we may be able to work with you directly if it goes pass this date
A: Dennis (PBH) – We are concerned with timely filing now.
A: Thelma (DMH) – Yes, we realize that. Let's see how this will go and if we do not make the end of October deadline, we will setup a meeting and discuss some options with you.

Q. Tom (WH) – Will alternative services be subjected to the same adjudication process as other claims?
A. Thelma (DMH) – Yes.
Q. Jeanna (Mental Health Partners) – Could you please give us the process as to filling out the form for these services before sending it to you?
A. Thelma (DMH) – Yes, the process is that you have a service that you would like to provide and you find this it on the form on the DMH website. Fill out this form, send it in to the Division, to the Budget Office, then the Budget Office receives it, and then the best practice team receives it, which is lead by Bonnie Morel. She then distributes it. If it's a MH service, DD service, or SA service she gives it to the correct Divisional person to review it. They look at it and if they have any questions, they will contact you about it. Next, they give the form back to Bonnie, who will give it back to the Divisional Workgroup Meeting, which will have people from all the disciplines there. We review it (if someone from SA have a comment about MH services and they comment), then after we approve it, it is sent to the Budget Office to get a rate. The Budget Office reviews the suggested rate requested for reasonableness. If there are no questions at this level and suggested rate request is approved, then it is forward to ELT for review, discussions and approval. Then we will send notification to the LME once approved and the rate is entered into the rate file and once rate is uploaded, you can start submitting claims for this service. This is a huge process and over time, we are expecting the process to get quicker as we move forward.

3. Reporting of County Funds – The Division has been meeting in a smaller subgroup to discuss reporting of County funds. Legislative mandate stating we will track County funds and report that information to LOC. For those who attended this meeting, the latest update is there is a spreadsheet that will be sent out to you in the next few days or the next couple of weeks that will have you reporting on how you spent county funds for the fiscal year 2007/2008. Once you receive this spreadsheet, you will have approximately 4 to 5 weeks to review it and return that information to the Division so we can have it for the legislatures when they return to session to discuss it or whenever they request it. The meetings dates have been scheduled and are unknown at this time. The Division wants to be prepared with that County information when we are asked to report it. Phillip is currently reviewing this information and it will be forwarded to your Area Program Directors, then to your Finance Officers. Ongoing, the subgroup recommended that we continue to use spreadsheet that is similar to the 2007/2008 reporting. Going forward, the LMEs should be able to account for their County funding on this spreadsheet, but if the LMEs want to get penetration rates and credit for more clients served, then what is actually in IPRS, then we are going to setup TNC pop group for you to enter in clients that are receiving County funds only. This will allow you to use the current array to account for reporting those services and also, to setup alternative services for County Funds to allow you to account for funds that are spent there. Also, this will allow you to account and add additional clients onto the penetration rates of

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	the LME. Now this information is not formal, but is the recommendation of the group. Q: Thelma (DMH) – Tommy is this information accurate from what you remembered from the group? A: Tommy (Sandhills) – Yes, you covered the information very well. We had five LMEs that were represented in the group and someone from NC Council has been invited including a member of the legislative LOC. Thelma (DMH) – Are there any questions or concerns regarding the reporting of the County Funds? 4. IPRS Simplification – There has been much discussion within our workgroup, your Area Program Directors, and Leza Wainwright and you all probably have heard rumors about what is involved. You will be receiving a memo sometime this week or next week detailing all the changes. We are eliminating 23 of the pop groups and combining them into smaller pop groups. We are creating one new pop group for Adult MH. The directors have told Leza, they want to eliminate the hierarchy for where funds are paid. They want the clients to be enrolled as either MH clients, DD clients, or SA clients. What the Division has proposed to do is to end-date the currency which allows an individual to be enrolled in more than one pop group. October 1st, or the date set going forward, individuals will be enrolled in one pop group only and will be paid out of that fund. So if you have a MH client that is also a SA client, it will pay only out of the MH pop group and you will end-date the SA part of it or if you have a SA client who have some MH issues, you will end-date the MH pop group and have them predominantly in the SA pop group and have the funds pull down SA funds. Many of the LMEs who participated in the meeting felt that this was not a good solution or something they wanted. Some of you will be contacted to go talk with your directors about why this would be an issue for your LME and then have them contact Leza Wainwright if they really want to change that part of the simplification. Also, within IPRS Simplification process, we are expanding the array of services in the pop groups that are remaining. For example, if you combine the two Adult MH pop groups, then you will have the services that were available under either one of them combined into the one new pop group. We are eliminating the matrix because once the pop groups have been simplified; it will no longer be needed. Once again, this process was decreed by legislation. We must look at how we can simplify IPRS and listen to what the Area Directors wanted as part of the IPRS Simplification process. Spencer Clark has been working on writing the memo per the meeting held last Friday and based on this meeting some of you are planning to speak with your Area Director to see if you want to implement all of these items presented. Are there any questions or concerns related to the IPRS Simplification process? Q. Kelly (Durham) – Will the claims deny if the client is enrolled in two target pop groups? A. Thelma (DMH) – Yes, and we are working out the details on that. What we hope to do is have a certain date as to when you can start enrolling individuals so that you may get all the enrollment changed and corrected, then have a cutoff on another date, for example October 1, 2008, giving the LME the chance to review their clients eligibility and to submit the 834 files to change the eligibility, then the hard cutoff date being December 31, 2008. In your case you have a client who is eligible in two different pop groups; they can continue to have the concurrency work for the existing eligibility until December 31, 2008. Between now and the end of December, be deciding which pop group you want the client to remain in and which one you will end-date. Then we would create some type of report by December to send out to all of you to let you know where you still have concurrency issues in your eligibility groups. Come December 31, 2008 if you have something that has

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	someone that is dual enrolled, we would end-date those as an option. Please note, this has not been decided, but is just one of the possibilities to be considering. If October 1st is the start date, then the concurrency will go in so that the clients that you will be enrolling new, you will have to pick a pop group to put them in and you will not be able to dual enroll them. A. Kelly (Durham) – I think the directors are drastically underestimating the amount of time this process is going to take. A. Thelma (DMH) – You have just summed up exactly the discussion we had in the last Friday in the meeting. This has all been decided and decreed. So, if you are concerned as many of the LME's participates were last Friday, their task was to go and discuss their concerns with their directors, thus encouraging your directors to contact Leza Wainwright if you are asking her to change this process. Q. Jeanna Lauffenburger (Mental Health Partners) – This means that when we get rid of the concurrency on dual diagnosis clients, we are also going to have the provider is set up, right? So if the provider is a SA provider and the client is getting the MH funding, and the SA provider doesn't have the target pop eligibility to draw MH dollars, then the SA provider cannot get paid. Is this sort how it is supposed to work? A. Thelma (DMH) – Jeanna, are you saying the SA provider are only enrolled to do SA services and your MH providers are enrolled to do MH services, is that what you are saying? Q. Jeanna (Mental Health Partners) – Yes, whenever a provider is not comprehensive, it can also, provide those services. In order to manage our dollars better, when will the SA provider draw down the MH dollars? A. Thelma (DMH) – That will not be a problem, because you will have your client enrolled in SA pop group and if the provider is also enrolled to bill for those SA services for that SA pop group, then that service should pay. Q. Jeanna (Mental Health Partners) – Not on the MH side, though, because we can't dual enroll the client in a target pop group, unless there is a target pop that represents dual diagnosis, then how are we going to be able to get the SA provider to pay out of the SA dollars and the MH services pay out of MH dollars? A. Thelma (DMH) – This should work out ok, because the client would be enrolled in one of the MH pop group or one of the SA pop group. So your SA Providers will have to bill for those SA services for that SA client and then your MH providers will have to bill for MH services for your MH clients. Q. Jeanna (Mental Health Partners) – Then we would have to allow the setup on my SA provider to include the MH services to allow the draw down of the MH dollars? A. Thelma (DMH) – Yes, but look at your service array. When we were reviewing these to see how many service will be affected, it's mainly the enhanced services, such as services like SACOT and SAIOP for SA. Most of these are not allowed under a MH - only pop group, but you would want your qualified SA provider to perform those services which are at a higher level. For example, family counseling which is allowed under DD, MH, and SA. We will be sending you a merged service array, when this all gets announced so that you can see what services have been blended or merged together. Basically on the service part, we are not going to have a cross-over of SA into MH. What we will be doing is combining the MH services of the two MH pop groups into one. There will be some SA services blended into the MH pop groups, but some will not. Q. Beth (Pathways) – The memo detailing this is coming out in the next couple of weeks? So are you saying that we have only a few weeks to retrain our staff and providers on the computer systems regarding these changes? A. Thelma (DMH) – No, we are going to have a begin date so that those of you who want to start immediately can start, but the end date I believe is going to be 90 days past the start date. Q. Beth (Pathways) – So there will be a transition period?

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	A. Thelma (DMH) – Yes, is a transition period and we are looking at it to be 90 days. The concern was to get this available to you as soon as possible. A. Beth (Pathways) – Ok. Q. Terry (Eastpointe) – On the question the other LME had, in regards to receiving services from DD and SA, what would be the determination be to where the money will be drawn from? A. Thelma (DMH) – What we are trying to express here is that we do not want the billing to drive clinical needs. We still want you to determine the eligibility or have your providers determine the eligibility by what that client's needs are. And yes, you will need to decide, but it needs to be the clinical decision by looking at the new pop group definition on where that client's needs are. Then the billing, if there's a case where the DD client that needs DD and also need family counseling, then we would look at trying to add the family counseling service to DD if that's something that has to be done. Q. Terry (Eastpointe) - So we as LMEs are going to have to make a decision between all of our dually diagnosed pop groups, if we want them to fit in, right? A. Thelma (DMH) – That is correct. And we had said at first, that we could do this systematically for you and after the discussion with our workgroup, the individuals in the meeting said no. If it was to start October 1st if you have a new client came in, you would enroll them in one pop group and we could get the enrollment setup so that you can enroll them with a start date of January 1, 2009 and would be in effect to the end of December. But, yes, if we put the concurrency part in, if that goes through, and the decision is to put that in the beginning, then your current client that is enrolled in more than one pop group will be valid until the end of December. Come December 31st, you've got to have one of the two pop groups or however more you have your clients enrolled in, they would have to be end-dated December 31, 2008 and you would leave one main pop group for them to receive service from. Q. Terry (Eastpointe) – Will there be some type of criteria, to help us determine whether or not a diagnosis fits a target pop group? Will there still be a matrix or category of diagnosis covered underneath the pop group? A. Thelma (DMH) – The diagnosis codes are being merged for the pop group and so it is posted on the DMH website that will be posted October 1st. We are working on getting approval on all of those. As far as a matrix, no, we are eliminating it. Q. Marianne (Smoky) – I would like to reiterate to make sure I understand. There will be some brand new target pop groups, but the criteria for these will change and they will help the clinicians to determine which ones are appropriate for clients who are dually diagnosed. A. Thelma (DMH) – No, there will be only one new pop group and that is for Adult MH. Let me give you an example. One of the main SA pop groups is ASTER, one that is going away is ASDWI, Instead of having to look at the service definition, those clients under ASDWI will now fit under ASTER and the ASTER pop group definition will include the information under the ASDWI pop group. Under the service definition, which Spencer is working on, when it becomes a blended pop group like ASTER is taking in ASDWI and ASHMT, then those qualifications will be under ASTER instead of under separate target pop definitions. Q. Terry (Eastpointe) – It is still the clinician's responsibility to determine diagnosis and current treatment should be, All the LME is required to do is to help them manage their decisions and help them communicate them upward, right? A. Thelma (DMH) – Yes. Out of all the simplification information discussed the workgroup seemed to be the most excited about condensing and eliminating some of the pop groups because it would make it easier for their providers to determine eligibility. Q. Victoria (Albemarle) – As far as the rate request, will this be affected or

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	are we required to send in a new rate request for the new target pop or will they be end-dated and we will need to send in all new rate requests? A. Thelma (DMH) – Wanda Mitchell was unable to attend last week's meeting. We will ask her about merging the rates and how that's going to work. Donna (Onslow) – This is different issue on the target pop. We have a detox unit and that detox unit takes in clients from different counties. We have a problem there, because the target pop is enrolled in a different county and we can't file under that target pop and we can't change it because it would over lapse that other county. Q. Thelma (DMH) – That is the same issue we currently have, right? You and the other LME get together and decide who is responsible for that client and if they could use your billing number as the referring provider and submit that claim so it will pay out of their budget, instead of your budget? A. Donna (Onslow) – I really do not know how to handle this issue, because this question was forwarded to me by another department. I know that when I deal with it, I can contact that county and say 'look the date, time for this detox services is set to expire in a certain amount of days'. We work it out by updating the end-date and start over in order to handle issue. Now, if it's a different type of target pop for this detox service on file for the other county then it's no problem. A. Thelma (DMH) – It will work the same way, because everyone is going to have the same pop group they would work. So if a pop group is has merged, they are going to be merged for all clients. Then you would want to get on the phone and say 'this used to be ASDWI and now it is merged into ASTER. Is this client eligible on these dates'? So you will still have to pick up the phone and call them and ask which pop group covers that service to make sure that client is enrolled. Q. Donna (Onslow) – If they are enrolled in that other county, we will still get a denial. A. Thelma (DMH) – You will be using the same process you use today when you communicate to the other LME to receive payment as you will use within your pop group. Whatever process you are currently using is the same process you will use to contact the other county. Q. Donna (Onslow) – Basically, by the time it reaches me, the claim has already denied, because the provider hasn't contacted the other county. So I guess what we need to know is exactly what process should we be using, because by the time it gets to me, I would call that county and say 'could you end-date eligibility so that we could get this cleared'? Is there another way? Q. Thelma (DMH) – Would you mind contacting IPRS Q&A so that we could step you through this process? If you would send us an email with this question, one of us will call you and step you through this process. A. Donna (Onslow) – ok. Q. Marianne (Smoky) – I have another question relating back to the Jeanna's question about the providers. The new target populations that are added completely from scratch, will the providers need to enroll the new target pop themselves or is this something you all will do? A. Thelma (DMH) – We have talked about that, and we believe we can do this systematically for you. Again, there is only one new pop group that is projected and that is for Adult MH. It's combining our two existing Adult MH target pop groups. What we can do is go in and for where you have attending provider as a MH provider or multi-specialty with MH with SA or MH with DD, or any of the combinations that is MH, we can you add that new pop group so that you will not have to enter in on every single MH provider. Now, for the new MH providers in the future, when you select all, it will have the correct pop groups listed. A. Marianne (Smoky) – That's great, thanks. Q. Faye (Mecklenburg) – Could we not collect type/specialty funds to one multi-service and have the target pops to be selected for every single

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	provider to streamline that process? Whether it is a MH, DD, or SA, funds will pull from one? Q. Thelma (DMH) – Could you please repeat your question? Q. Faye (Mecklenburg) – Streamline the multi- services to crossover every disability area, then select all of the target pop groups, so that regardless of where he client ends up, the provider will be covered. A. Thelma (DMH) – There is that option, now, that you can now enroll the providers. A. Faye (Mecklenburg) – There is a type/specialty you enter and you have choices like multi-service, MH, DD, SA, then you select which target pop applies under that provider. If we select every target pop group for every single provider with a multi-service type/specialty, it should decrease the number of denials against that provider. Q. Thelma (DMH) – Clinically, are most providers able to service MH, DD clients? Is this clinically possible across the board? A. Faye (Mecklenburg) – Unless the provider is a comprehensive provider and there are still a lot of smaller agencies that specialize in some things. Q. Thelma (DMH) – What we will do is take your suggestion to our Divisional workgroup meeting, and then let our clinical people decide on that. Let me reiterate your request. You want an option under selecting type/specialty for a new provider to allow that provider do perform MH, DD, or SA services, right? A. Faye (Mecklenburg) – Yes, or all three. A. Thelma (DMH) – Ok, let us take it to the Divisional Workgroup and see what our policy book says about this. Q. Marianne (Smoky) – Isn't there special criteria required for the provider to be able to be designated as SA? A. Thelma (DMH) – Yes, I believe there is. A. Marianne (Smoky) – I do not believe MH and DD is the issue. I believe the problem lies in whether or not the provider meets the criteria for SA. A. Thelma (DMH) – We will take your policy issue to our Divisional Workgroup for review. A. Jay (Budget Office) – Thelma, it seems that if you did that, you may be looking at another Community Support situation if you are designating a provider to provider all of these services when essence they were not qualified to do so. A. Thelma (DMH) – There's the key, they would have to be qualified and I clinically do not know if the policy individuals feel that there is a provider out there that can do all these services. For new Community Support there are all sorts of criteria that you must go over before the provider becomes endorsed, then enrolled in Medicaid. We will take this back to the Divisional Workgroup for review. I feel that they may so no, due to the special requirement for SA. A. Faye (Mecklenburg) – You are getting rid of the concurrency issue and the consumer can be enrolled in one pop group at a time, then the client could be enrolled in a target pop that is not covered for that provider. For example, the provider is SA and the client is enrolled in MH target pop group. So when the claim is submitted, the system will look at the MH target pop criteria. This upholds for all providers. A. Thelma (DMH) – This is true, however I do not believe we are going to add SA services underneath the MH pop groups. But if they are doing something that is service that goes across all pop groups, such as therapy or counseling then this would be a different story. Faye if you would please forward us an email to IPRS Q&A indicating why you would like this, this would probably be helpful in forwarding to our Divisional Workgroup and you would have everything mentioned you wanted covered to state your case. A. Faye (Mecklenburg) – Ok A. Thelma (DMH) – Depending on timing and what other projects we may

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get assigned to, we have a slot assigned to IPRS for FARO this fall to go over many of these topics as we can. I am certain we will go over the IPRS Simplification and give you exact detail and written documentation before October, I'm sure.
A. Jeanna (Mental Health Partners) – There is no way in the programming to allow you to allow dually diagnosis consumer to be enrolled in two target pop groups and you pay based on the target pop group that came on the claim. So if I have a dual diagnosis and I got a SA provider service coming in and if I put the SA target pop group it will pay out of the SA dollars, but if I have the MH provider doing something, I put the MH target pop group and that's where the dollars will come from. The programming will not allow that.
A. Thelma (DMH) – The programming is that the client can be enrolled in one target pop group and the services it will pay for that attending provider has to be enrolled in order to pay from that pop group and the service has to be listed under that pop group.
Q. Jeanna (Mental Health Partners) – So there is no way for me to change target pop group according to which funding you need the service to come out of so that you can statistically track where the dollars were really used for the MH services versus the DD services versus the SA services?
A. Thelma (DMH) – Well you can do that if you have a client enrolled in MH and suddenly they need SA service such as SAIOP. Then you would end-date them in MH and enroll them in SA to pay for that SA Service.
Q. Marianne (Smoky) – What if you have a SA person and a SA target pop group, If they get an outpatient therapy session and they have a MH diagnosis, will that determine which budget it comes from or will that be totally based at the target pop group level?
A. Thelma (DMH) – It will be based on the target pop group level. If that is the service covered under SA, then it will pay out of the SA funds. The Area Programs wanted predictability on where services were going to be paid. Once again, if you feel that this is not a simplified process, you need to contact your Area Directors, and then they will need to contact Leza Wainwright in order for the steps of the IPRS Simplification process to be change.

- IPRS Questions or Concerns

Eric (DMH) – Are there any IPRS questions or concerns?

Q: Beth (Pathways) – We sent in a question regarding our replacement claims to IPRS Q&A. Have you received any information regarding our issue? We are having problems with replacement claims processing because the original claim has no NPI.
A: Eric (DMH) – EDS is currently reviewing this issue and is gathering more information to identify the problem and to create a resolution to it.

Q. Tom (WH) – We are now under Single Stream Funding. I understand that the claims that are paid under Single Stream funding arrangements are reported on IPDR3833, but in the event that we refund the claim through the void process, how will this be reported back to us?
A. Eric (DMH) – There is CSR which identifies work analysis as well as programming to change some of the logic in that situation for adjustments for EOB 8586 claims. Solution has been developed and is being tested.
Q. Tom (WH) – Are the voids presented on the 835, now?
A. Eric (DMH) – Yes, they are.
Q. Tom (WH) – Is part of the solution is to present this information on the IPDR3833 report?
A. Eric (DMH) – Yes.

Q. Deborah (Wake) – Do we have an exact date in October when we can

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	stop billing for last fiscal year? A. Eric (DMH) – That date is October 23, 2008. • MMIS Updates Dana (EDS) – We do not have anything to discuss/report at this time. • Medicaid Questions or Concerns N/A **DMH and/or EDS Concluding Remarks:** For North Carolina Medicaid claim questions / inquires please call EDS Provider Services at 1-800-688-6696 or 1-919-851-8888 and enter the appropriate extension listed below or 0 for the operator. o Physician phone analyst (i.e. Independent Mental Health Providers) - 1 o Hospital phone analyst (i.e. Enhanced Service Providers / LMEs) - 2 **Roll Call Updates**

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